SIGNATURE

LEGALCARE

P.O. Box 968004, Schaumburg, IL 60196

Signature LegalCare®
Claim Form

PART 1: To be completed by EMPLOYEE

Employee Name *(please print)*	Member Identification #	Sex: ○ Male ○ Female	Date of Birth *(MM/DD/YY)*

Street Address/Apt. #	City	State	ZIP Code	Daytime Telephone Number

Employer Name	Is this service covered by other insurance? ○ No ○ Yes	If "YES", please give name and address of carrier.

I authorize release of any information regarding this claim to Signature LegalCare or its authorized representatives. I certify that the information provided in Part 1 and Part 2, if applicable, is correct and that the services described in Part 3 are completed legal services.

Employee Signature (*Required*) **Date**

I authorize payment of group legal benefits to the attorney who provided the services described in Part 3.

Employee Signature (*Required to Release Payment to Attorney*) **Date**

PART 2: Shown on the reverse side of this claim form must be completed if the claim is for a DEPENDENT

PART 3: To be completed in full by ATTORNEY ***Incomplete information may result in the delay or denial of the claim.***

Attorney Name / Firm Name *(please print)*	Social Security / IRS Identification #	State Bar Number	Are you a participating Attorney? ○ Yes ○ No

Street Address/Suite #	City	State	ZIP Code	Telephone Number

Service Code	Description of Services **(*Please be specific when using benefit code 25*)** *(Continued on the back)*	Date of Services Start *(MM/DD/YY)*	Date of Services Completion *(MM/DD/YY)*	Total Hours & Minutes	Total Charges	Amount Paid by Client
1.						
2.						
3.						

Did any of the services require a court appearance? ○ Yes ○ No
Please indicate the number to which this applies: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

If applicable, please indicate if the Covered Person was: ○ Petitioner/Plaintiff ○ Respondent/Defendant
Please indicate the number to which this applies: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

Modification of Child Support, Custody, and/or Visitation: Was there a divorce decree? ○ Yes ○ No

Did any of the services involve a contested matter? ○ Yes ○ No
Please indicate the number to which this applies: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

If services involved Real Estate, please respond to the following:
○ Check this box if for the Covered Person's primary residence.
Please check which applies: ○ Sale ○ Purchase ○ Refinance
If this was not a primary residence, please explain: _____

For Powers of Attorney Indicate if the Covered Person was the: ○ Grantor ○ Grantee
Were these durable? ○ Yes ○ No

If services were for bankruptcy, please indicate which applies: ○ Chapter 7 ○ Chapter 13 ○ Individual ○ Joint

My usual hourly rate is $_____. My fee(s) for these completed legal services does not exceed my usual and customary charge for the service(s) rendered. Questions concerning my fee may be reviewed by the insurer or its authorized representative. The services were performed by an attorney or a paralegal under direct supervision of an attorney. I am not related to the employee or dependent by blood or marriage.

Signature (*Required*) **Date**

IMPORTANT - READ CAREFULLY

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false, or to omit important facts. Criminal and/or civil penalties can result from such acts. Completion of claim form does not guarantee payment. Original signatures are required from the Employee and the Attorney for claim consideration. Copied signatures are not acceptable. Signature LegalCare will make final decision on whether or not the signatures appear to be original.

PART 2: To be completed only if claim is for Dependent

Dependent's name and address *(please print)*	Date of Birth *(MM/DD/YY)*	Sex: ○ Male ○ Female	Relationship: ○ Spouse ○ Child ○ Other:_____

Is dependent employed on a full time basis?

○ Yes ○ No If "YES", please provide name and address of employer.

If claim is for a child age 19 or over, please answer the following:

1. Is the child enrolled as a full-time student?

○ Yes ○ No If "YES", please provide name and address of school.

2. Is the child wholly dependent upon you for support and maintenance and claimed as a dependent on your Federal Income Tax Return? ○ Yes ○ No

3. Is child incapacitated? Please explain.

PART 3: To be completed in full by Attorney *(continued from front)* ***Incomplete information may result in the delay or denial of the claim.***

Service Code	Description of Services *(Please be Specific)* *(Continued from the front)*	Date of Services Start *(MM/DD/YY)*	Date of Services Completion *(MM/DD/YY)*	Total Hours & Minutes	Total Charges	Amount Paid by Client
4.						
5.						
6.						

Additional Comments (*Please attach itemized statement*)

General Information
The Signature LegalCare program is designed to allow you complete freedom of choice in the selection of an attorney. You should present this claim form to the attorney you select so that he/she can complete Part 3. Original signatures are required. Please refer to plan specifics for coverage level.

Claim Reimbursement
Reimbursement of attorney fees can be considered only if coverage under the Signature LegalCare program was in effect on the date(s) attorney services were provided. Coordination of Benefits (COB) provisions may apply if other legal expense coverage was also in effect. In addition, frequency limitations may apply to certain legal services.

Notice to Non-Participating Attorneys
If you are interested in learning more about the Signature LegalCare program and how you can become a Participating Attorney, write to us at the address shown on the front of this Claim Form or call 800-848-2012.

For Internal Use Only

Receipt Date	Control #	Branch	
Effective Date	Coverage Level	Plan	
Batch Number		QR	RV
Batch Number		QR	RV
Comments			